The Dining-Room Caper

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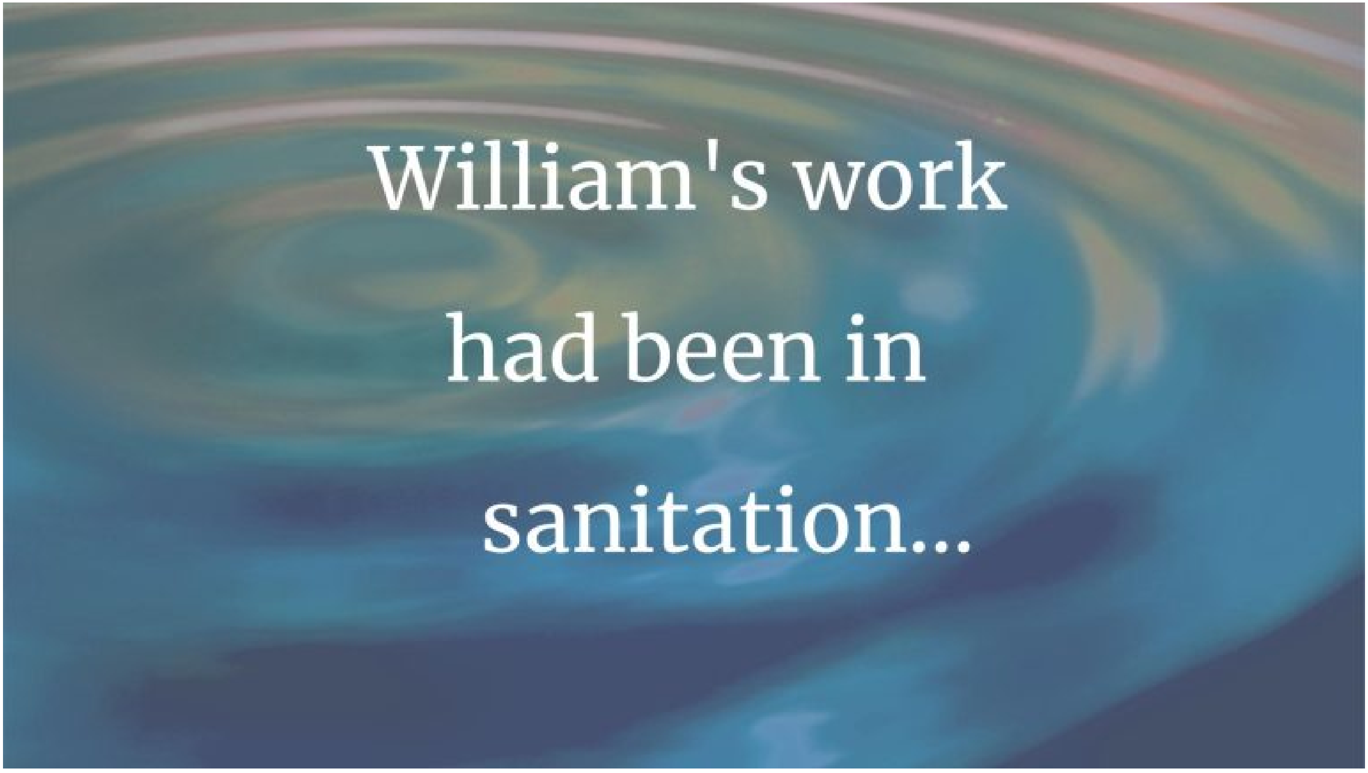

After fifteen years as a physical therapist in the long-term care industry, I’d vowed never again to get overly attached to a resident. Although I accepted my patients’ inevitable physical and cognitive declines, the deaths of those I had cherished took too much of an emotional toll: It felt like losing a grandparent, repeatedly.

Then William entered our facility.

Like most, he’d come reluctantly, after years of living on his own despite advancing Parkinson’s disease, and only after incessant prodding from his niece and nephew.

William’s work had been in sanitation—a difficult, dirty job looked down upon by many in this small community. His motto was: “Not all trash is destined for the landfill. Trash can be treasure!”

Despite his less-than-glamorous vocation, or maybe because of it, William was a lifelong ladies’ man— “Greenville’s most eligible bachelor,” in his own words. He was admired by the facility’s (few) men, though less so by some of the women who recalled his youthful antics.

Be that as it may, William was a charmer. His broad smile and twinkling eyes easily lured me, and other staff members, into long, wide-ranging conversations that most of us didn’t have time for, and his engaging personality helped him adapt to nursing-home life.

Despite his advanced neurological decline, William was fiercely independent. He dressed dapperly and especially relished meals in the main dining room, where he could socialize with others, particularly those identifying as female.

The main dining room was the facility’s most luxurious space—bright and cheery, with floor-to-ceiling windows, silver chandeliers and beautiful color-coordinated drapery and wallpaper. The tables sported matching linens; glass shakers held the salt and pepper. Meal orders were taken by the “waitstaff” and served restaurant-style, with no plastic trays in sight. The room was open only at noon, which increased its allure.

One could argue that eating there was the closest the residents came to their earlier lives. Having sacrificed so much autonomy, they found the main dining room a welcome return to normalcy. Music played, people laughed—and being there meant, as William put it, “I finally belong.”

But eating there was also a privilege. To qualify, residents had to feed themselves independently, on a diet “regular in texture.” This rule served two purposes. One: The dining room was not large, so when residents could no longer eat independently, they ceded their spot. Two: Most of the diners were unwilling to watch a peer struggle to eat; and they found the sight of ground or puréed foods offensive. Even in nursing homes, bias exists: The haves and have-nots are replaced by the can- and can’t-dos.

I couldn’t decide whether watching a fellow resident being fed fueled the diners’ fears of a similar fate, or if their sympathy for the peer dampened the general mood. Regardless, residents who could no longer eat independently were returned to their home units to dine—a blow to their self-esteem.

As a staff leader, I supervised the dining room every two weeks. With foreboding, I noticed William’s growing struggle with self-feeding and swallowing, due to his Parkinson’s. I realized that he was on the cusp of losing his cherished dining-room privileges.

We discussed this, and he asked me to help him keep his place at the table. As a rehab professional, I was well equipped to pull together the needed supports, so we quietly conspired to prolong his presence.

At my request, the occupational therapist crafted adaptive feeding utensils to help compensate for William’s dwindling fine-motor skills.

When his fellow diners questioned these utensils, William replied, “The adaptive equipment enables me to eat, much as the glasses that most of you wear enable you to see.”

He *might* have been coached in this response; regardless, it worked! The dining-room director agreed, and, to our mutual delight, William lived to dine another day!

A few weeks later, the speech therapist taught William strategies to optimize his swallowing and reduce his coughing outbursts. We also rearranged his seating so that he sat with more tolerant diners, and with his back to the room, to be less conspicuous.

As time passed, and William continued to decline, I began visiting the dining room at meal’s end, ostensibly to help residents return to their rooms. When everyone else had departed, I sat with William and fed him the rest of his dinner.

“I’m sorry for taking up so much of your time,” he said, not realizing how much I enjoyed our conversations and the un-rushed opportunity to get to know one another.

In truth, William and I secretly enjoyed breaking the rules together. For him, this meant holding onto something special—enjoying a meal. For me, it meant preserving a man’s dignity for as long as possible.

Unintentionally, in the spirit of friendship, William taught me about tolerance, acceptance, empathy and respect. I learned that you achieve a true sense of tolerance and acceptance because of, not in spite of, differences or limitations. That connections sparked by empathy can grow over time, fostering greater mutual respect. William and I developed a professional relationship that transcended that of healthcare provider/patient: We became true partners in his long-term-care journey.

In early December, nine months into our dining-room charade, two things happened. First, the dietary director announced a slow, perplexing depletion of silverware. His assumption: The staff had been carelessly throwing it out after meals. His directive: “We must be more conscientious.”

Second, more distressingly, William suffered a significant stroke and was hospitalized for several days. During that time, a modified barium-swallow test revealed that his impaired swallowing put him at severe risk for aspiration pneumonia. The recommendation: nothing by mouth (NPO), and a permanent feeding tube.

What a poignant irony. William would now be denied his biggest pleasure, which he’d fought so hard to maintain: the dining-room experience.

The hospital’s recommendation turned out to be a death sentence, literally and figuratively. In consultation with his family and his physician, William chose to return to the facility with orders for comfort measures only, NPO—and no feeding tube. I stole a few hours here and there to sit with him (the twinkle still in his eye) and hold his hand. He died about a week later, comfortably and on his own terms.

Shortly thereafter, as William’s niece and nephew collected his belongings, they found Christmas-wrapped boxes with their names on the tags. Inside we were astonished to see handmade wind chimes—crafted, presumably, from the main dining room’s knives, forks and spoons.

Well played, William! I thought, smiling at the memory of my rule-breaking friend.

Then I wondered: *Have I broken my own rule as well? Have I let myself get* *overly attached?*

With relief, I realized that I didn’t see William as a grandparent figure. Though I felt sad that he had died, I wasn’t overcome with grief; rather, his death brought a sense of peace. I felt strong and proud of having formed our relationship, built on mutual admiration and respect. My time with William made me better—not a better physical therapist, but a better human.

Eight years later, having left nursing care, I purchased a vacation home in Maine. Settling in, I heard a faint, delicate metallic ring and went to investigate. On a backyard elm tree hung a wind chime made of silverware!

In that moment, I realized that William is still with me in spirit. These precious wind chimes are my treasure that is not destined for a landfill: They remind me of my special patient, my special friend, and everything he taught me.